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October 24, 2000

Re: BACKMAN, Daniel
Source of Referral: Dean Otaka, M.D.

CHIEF COMPLAINT: Neck pain and left shoulder and arm pain.

HISTORY OF PRESENT ILLNESS: The patient is a 41-year-old gentleman with a long history of neck pain and radicular arm pain. The onset of symptoms began with a motor vehicle accident in October 1988, when his resting vehicle was broadsided by a vehicle driven by a police officer. He developed neck pain and then, over the next few days, left arm pain. He was treated conservatively for many years, including chiropractic manipulation and nonsteroidal anti-inflammatories. In 1997, the pain in his neck began to increase with pain also into both shoulders. After continued conservative therapy, an MRI was eventually performed, which reportedly showed a C4-5 midline disk extrusion. He was evaluated by Dr. Yoshio Hosobuchi at that time, and the patient elected to continue with conservative measures. He was eventually seen by Dr. Terry Smith, who performed a C4-5 Cloward-type anterior diskectomy and fusion using autologous hip graft. Postoperatively, his neck pain improved. He wore a collar for the first three weeks after surgery, and he was released to work at approximately six weeks. His work involved a lot of turning of his neck, lifting, and being in awkward positions for long periods of time. Approximately six months after returning to work, he began having increasing neck pain that progressed to bilateral shoulder pain as well as pain in both arms, left greater than right. He also notes paresthesias in both hands, mostly in the ulnar distribution, left greater than right. The patient has seen Dr. Gregory Chow, Orthopedics, and more recently has been seeing Dr. Dean Otaka for conservative management. Because of continued pain, the patient has been taking narcotics on a chronic basis and has been seeing Dr. Lind, a pain management specialist. The patient is here for another opinion regarding the possible etiology of his symptoms and the potential treatment options.

PAST MEDICAL HISTORY: Positive for an anxiety disorder, for which he is seeing a psychiatrist. He also has hyperlipidemia, familial type, and has had hospitalization for pancreatitis in the recent past. There is also history of hypertension. The patient's cervical spine surgery was in March 1999.

CURRENT MEDICATIONS: OxyContin, alprazolam for anxiety, Norvasc, and Tri-Chlor.

ALLERGIES: None known.

EXHIBIT 5

FAMILY HISTORY: Both parents have hyperlipidemia. Father has hypertension and previous history of MI.

SOCIAL HISTORY: The patient works as an investigator for an insurance company, as well as in law enforcement. He has been off work since the end of January 2000.

REVIEW OF SYSTEMS: Respiratory - Patient has chest pain with anxiety, but no pulmonary problems were found on workup. Cardiovascular - Negative. Psychiatric - Positive for anxiety disorder noted above. Neurologic - Patient denies any lower extremity weakness or spasticity. GU - No history of incontinence or bowel or bladder dysfunction. Musculoskeletal - Patient has a history of neck pain as noted above. Symptoms tend to be aggravated by upright activities. He also notes limitation of motion with decreased ability to rotate his neck to the left side.

PHYSICAL EXAMINATION: General appearance is that of a 41-year-old male in apparent mild distress due to neck pain. HEENT - Healed left anterolateral cervical incision. Neck with decreased lateral rotation to the left. Spurling maneuver negative bilaterally. Motor testing with 5/5 strength in all extremities. Tone is normal in all four extremities. Gait is also normal. Sensory testing reveals decreased pain and temperature in an ulnar distribution on the left side. The right side appears intact, although the patient subjectively does have some distal numbness and tingling of both hands, mostly ulnar. Reflexes are 1 to 2+ and symmetrical. No pathological reflexes are noted. Coordination is also within normal limits.

DIAGNOSTIC IMAGING: Cervical spine x-rays from March, April, and July 1999 are reviewed. The March films are recent postoperative study showing dowel-type graft at C4-5. The April films show evidence of partial collapse and ventral protrusion of the graft. The July study shows evidence of bony fusion at C4-5 with residual narrowed disk space at this level. The ventrally located graft has been absorbed.

MRIs from January and December 1999 are also reviewed. The January study shows evidence of a midline disk extrusion at C4-5 and a small osteophyte on the left side at C5-6 with some minimal canal narrowing of questionable significance. The December study shows evidence of fusion at C4-5 with persisting loss of cervical lordosis, as also noted on the January study. The canal at C4-5 appears to be well decompressed in the midline with no significant cord compression. The small osteophyte noted at C5-6 appears to be unchanged. At C4-5 there is stenosis of both lateral recesses, left greater than right, due to residual osteophytes.

IMPRESSION:

1. Persistent cervical radiculopathy secondary to C4-5 lateral stenosis, left greater than right.
2. Chronic neck pain due to cervical spondylosis; rule out instability.
3. Status post anterior cervical diskectomy and fusion, C4-5, using Cloward technique.
4. Mild lateral stenosis, C5-6 on the left, of questionable clinical significance.
5. Anxiety disorder.
6. Narcotic dependence.
7. Familial hyperlipidemia.
8. Hypertension.

RECOMMENDATIONS: Further diagnostic imaging studies are necessary to complete my evaluation. The patient should undergo flexion-extension lateral cervical spine x-rays and a repeat cervical MRI to reassess the status at C4-5 and C5-6 (last study 12/99). The patient will return to my clinic for reassessment and final recommendations after these studies have been completed.

Jon F. Graham, M.D., F.A.C.S.

JFG/lmc
cc: Dean Otaka, M.D.